Ear Nose and Throat Consultants of East Tennessee

History and Physical

Date: Chart Number:					
First Name:		M.I. L	ast Name:		
Age: Date of l					
Drug Allergies: Yes			Medical History: Diabetes Yes / No High Blood Pressure Yes / No Heart Trouble Yes / No Cancer Yes / No		
Pharmacy Name/Numb	er:		Stroke Yes / No Arthritis Yes / No Bruising/Bleeding Yes / No Other Health Problems:		
Circle all Prior Surg	eries:		1		
Heart Surgery Sinus Surgery Ear Surgery Back Surgery	Gallbladder Remov Appendectomy Hernia Repair Skin Cancer Remov				
Tonsillectomy			Social History:		
Other:	Ear Tubes		Tobacco Use:		
 Family History: Any	v Significant Illness	205?	Have you ever smoked? Yes / No Packs / day		
Mother:	Father:	Siblings:	How Long If quit smoking, how long ago? Alcohol Use: drinks/day, wk, month		
			Illicit Drug Use: How often —		
			Occupation:		
			If patient is a child, is he/she in Daycare? Yes / No		
experienced:			presently experiencing or have previously		
Good Health	Yes / No		h Mouth Sores		
Recent Weight Change		Cough	Dental Problems		
Fatigue		Chest Pain	Painful Breathing		
Hearing Loss		Neck Stiffness	Spitting up blood		
Ringing in Ears		Dizziness	Seizures ing Numbness		
Earache or Drainage Nose Bleeds	Difficulty Swallowi Vocal Hoarseness		Enlarged Lymph Nodes		
Sore Throat		Sinus Problems	Bad Breath or Bad Taste		
Medications: Please	list all medications	you are taking, in	cluding over-the-counter medication:		

Medication:	Dosage:	How Often:	Who Prescribed:	(In office use)